ADMINISTRATION OF MEDICATION - HARRISON COUNTY SCHOOLS

Student's Name: ______________________________ Birthdate: ____________

School: ____ Grade: ______

Medication (Exact Dosage): ____

Time(s) for Giving: ____

Directions for Giving: ____

Comments: ____

____

Physician's Name: ____________________________ Phone Number: __________

Physician's Signature: __________________________ Date: ______________

Parent's Signature: ____
Approving the Administration of the Medication

Date: ______________

RELEASE OF LIABILITY

I, the parent of and/or legal guardian of ______________________, enrolled at ____________________, realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child the medicine prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements.

______________________________ ______________________________
Parent or Guardian's Signature Date:

______________________________ ______________________________
Principal's or Designee's Signature Date:

☐ Check here if this form also serves as the student's Section 504 accommodation where the only accommodation needed is to receive medication.

THIS FORM MUST BE UPDATED ANNUALLY

A SEPARATE FROM MUST BE FILLED OUT AND SIGNED FOR EACH MEDICATION